General Assembly **Amendment**

February Session, 2004 LCO No. **5323**

HB0568905323HD0

Offered by:
REP. DYSON, 94th Dist.
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To: Subst. House Bill No. **5689** File No. 608 Cal. No. 402

"AN ACT PROVIDING FUNDS FOR THE DEPARTMENT OF MENTAL RETARDATION (DMR) WAITING LIST."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. Subsection (a) of section 17b-239 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) The rate to be paid by the state to hospitals receiving appropriations granted by the General Assembly and to freestanding chronic disease hospitals, providing services to persons aided or cared for by the state for routine services furnished to state patients, shall be based upon reasonable cost to such hospital, or the charge to the general public for ward services or the lowest charge for semiprivate services if the hospital has no ward facilities, imposed by such hospital, whichever is lowest, except to the extent, if any, that the

commissioner determines that a greater amount is appropriate in the case of hospitals serving a disproportionate share of indigent patients. Such rate shall be promulgated annually by the Commissioner of Social Services. Nothing contained herein shall authorize a payment by the state for such services to any such hospital in excess of the charges made by such hospital for comparable services to the general public. Notwithstanding the provisions of this section, for the rate period beginning July 1, 2000, rates paid to freestanding chronic disease hospitals and freestanding psychiatric hospitals shall be increased by three per cent. For the rate period beginning July 1, 2001, a freestanding chronic disease hospital or freestanding psychiatric hospital shall receive a rate that is two and one-half per cent more than the rate it received in the prior fiscal year and such rate shall remain effective until December 31, 2002. Effective January 1, 2003, a freestanding chronic disease hospital or freestanding psychiatric hospital shall receive a rate that is two per cent more than the rate it received in the prior fiscal year. Notwithstanding the provisions of this subsection, for the period commencing July 1, 2001, and ending June 30, 2003, the commissioner may pay an additional total of no more than three hundred thousand dollars annually for services provided to long-term ventilator patients. For purposes of this subsection, "long-term ventilator patient" means any patient at a freestanding chronic disease hospital on a ventilator for a total of sixty days or more in any consecutive twelve-month period. Effective July 1, 2004, each freestanding chronic disease hospital shall receive a rate that is two per cent more than the rate it received in the prior fiscal year.

Sec. 2. Subsection (g) of section 17b-340 of the general statutes, as amended by section 45 of public act 03-19 and section 50 of public act 03-3 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(g) For the fiscal year ending June 30, 1993, any intermediate care facility for the mentally retarded with an operating cost component of its rate in excess of one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not

receive an operating cost component increase. For the fiscal year ending June 30, 1993, any intermediate care facility for the mentally retarded with an operating cost component of its rate that is less than one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to thirty per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred forty per cent of the median of operating cost components in effect January 1, 1992. Any facility with real property other than land placed in service prior to October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding October 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request, allow actual debt service, comprised of principal and interest, in excess of property costs allowed pursuant to section 17-311-52 of the regulations of Connecticut state agencies, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. For the fiscal year ending June 30, 1995, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, no rate shall exceed three hundred seventy-five dollars per day unless the commissioner, in consultation with the Commissioner of Mental Retardation, determines after a review of program and management costs, that a rate in excess of this amount is necessary for care and treatment of

facility residents. For the fiscal year ending June 30, 2002, rate period, the Commissioner of Social Services shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2000 costs to include a three and one-half per cent inflation factor. For the fiscal year ending June 30, 2003, rate period, the commissioner shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2001 costs to include a one and one-half per cent inflation factor, except that such increase shall be effective November 1, 2002, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until October 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate updated effective November 1, 2002, in accordance with applicable statutes and regulations. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. **[**Effective July 1, 2004, each facility shall receive a rate that is three-quarters of one per cent greater than the rate in effect June 30, 2004.**]** For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until September 30, 2004. Effective October 1, 2004, each facility shall receive a rate that is five per cent greater than the rate in effect September 30, 2004.

Sec. 3. Subsection (g) of section 17b-239 of the general statutes, as amended by section 68 of public act 03-3 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(g) Effective June 1, 2001, the commissioner shall establish inpatient

hospital rates in accordance with the method specified in regulations adopted pursuant to this section and applied for the rate period beginning October 1, 2000, except that the commissioner shall update each hospital's target amount per discharge to the actual allowable cost per discharge based upon the 1999 cost report filing multiplied by sixty-two and one-half per cent if such amount is higher than the target amount per discharge for the rate period beginning October 1, 2000, as adjusted for the ten per cent incentive identified in Section 4005 of Public Law 101-508. If a hospital's rate is increased pursuant to this subsection, the hospital shall not receive the ten per cent incentive identified in Section 4005 of Public Law 101-508. For rate periods beginning October 1, 2001, through September 30, **[**2005**]** 2004, the commissioner shall not apply an annual adjustment factor to the target amount per discharge. Effective April 1, 2005, the revised target amount per discharge for each hospital with a target amount per discharge less than three thousand seven hundred fifty dollars shall be three thousand seven hundred fifty dollars. Effective April 1, 2006, the revised target amount per discharge for each hospital with a target amount per discharge less than four thousand dollars shall be four thousand dollars. Effective April 1, 2007, the revised target amount per discharge for each hospital with a target amount per discharge less than four thousand two hundred fifty dollars shall be four thousand two hundred fifty dollars.

Sec. 4. (NEW) (*Effective from passage*) The Commissioner of Social Services, to the extent permitted by federal law, shall amend the Medicaid state plan to establish a pilot program serving not more than five hundred elderly or disabled state medical assistance recipients who are also eligible for Medicare and who voluntarily opt to participate in the program. Such program shall demonstrate the feasibility and cost effectiveness of delivering comprehensive health insurance coverage in a managed care setting to such recipients. The commissioner may include medical assistance services in the pilot program not presently covered in the state medical assistance program or other modifications to the state medical assistance program to

encourage voluntary participation in the pilot program.

Sec. 5. Subsection (a) of section 17b-365 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) The Commissioner of Social Services may, within available appropriations, establish and operate a pilot program to allow **[**not more than fifty persons**]** individuals to receive assisted living services, provided by an assisted living services agency licensed by the Department of Public Health in accordance with chapter 368v. In order to be eligible for the program, **[**a person**]** an individual shall: (1) Reside in a managed residential community, as defined by the regulations of the Department of Public Health; (2) be ineligible to receive assisted living services under any other assisted living pilot program established by the General Assembly; and (3) be eligible for services under the Medicaid waiver portion of the Connecticut home-care program for the elderly established under section 17b-342. The total number of individuals enrolled in said pilot program, when combined with the total number of individuals enrolled in the pilot program established pursuant to section 17b-366, as amended by this act, shall not exceed seventy-five individuals. The Commissioner of Social Services shall **[**use the current**]** operate said pilot program in accordance with the Medicaid rules **[**under**]** established pursuant to 42 USC 1396p(c), as from time to time amended.

Sec. 6. Subsection (a) of section 17b-366 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) The Commissioner of Social Services may, within available appropriations, establish and operate a pilot program to allow **[**not more than twenty-five persons**]** individuals to receive assisted living services, provided by an assisted living services agency licensed by the Department of Public Health, in accordance with chapter 368v. In order to be eligible for the pilot program, **[**a person**]** an individual

shall: (1) Reside in a managed residential community, as defined by the regulations of the Department of Public Health; (2) be ineligible to receive assisted living services under any other assisted living pilot program established by the General Assembly; and (3) be eligible for services under the state-funded portion of the Connecticut home-care program for the elderly established under section 17b-342. The total number of individuals enrolled in said pilot program, when combined with the total number of individuals enrolled in the pilot program established pursuant to section 17b-365, as amended by this act, shall not exceed seventy-five individuals. The Commissioner of Social Services shall **[**use the current**]** operate said pilot program in accordance with the Medicaid rules **[**under**]** established pursuant to 42 USC 1396p(c), as from time to time amended.

Sec. 7. (NEW) (*Effective July 1, 2004*) The Commissioner of Social Services may contract with a pharmacy benefits management organization or a single entity qualified to deliver comprehensive health care services, in accordance with section 17b-266 of the general statutes, as amended, to provide prescription drug coverage to medical assistance recipients receiving services in a managed care setting.

Sec. 8. Section 17b-274d of the general statutes, as amended by section 19 of public act 03-2, section 63 of public act 03-278 and section 83 of public act 03-3 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) Pursuant to 42 USC 1396r-8, there is established a Medicaid Pharmaceutical and Therapeutics Committee within the Department of Social Services. **[**Said committee shall convene on or before March 31, 2003.**]**

(b) The Medicaid Pharmaceutical and Therapeutics Committee shall be comprised as specified in 42 USC 1396r-8 and shall consist of fourteen members appointed by the Governor. Five members shall be physicians licensed pursuant to chapter 370, including one general practitioner, one pediatrician, one geriatrician, one psychiatrist and

one specialist in family planning, four members shall be pharmacists licensed pursuant to chapter 400j, two members shall be visiting nurses, one specializing in adult care and one specializing in psychiatric care, one member shall be a clinician designated by the Commissioner of Mental Health and Addiction Services, one member shall be a representative of pharmaceutical manufacturers and one member shall be a consumer representative. The committee may, on an ad hoc basis, seek the participation of other state agencies or other interested parties in its deliberations. The members shall serve for terms of two years from the date of their appointment. Members may be appointed to more than one term. The Commissioner of Social Services, or the commissioner's designee, shall convene the committee following the Governor's designation of appointments. The administrative staff of the Department of Social Services shall serve as staff for said committee and assist with all ministerial duties. The Governor shall ensure that the committee membership includes Medicaid participating physicians and pharmacists, with experience serving all segments of the Medicaid population.

(c) Committee members shall select a chairperson and vice-chairperson from the committee membership on an annual basis.

(d) The committee shall meet at least quarterly, and may meet at other times at the discretion of the chairperson and committee membership. The committee shall comply with all regulations adopted by the department, including notice of any meeting of the committee, pursuant to the requirements of chapter 54.

(e) **[**On or before July 1, 2003, the**]** The Department of Social Services, in consultation with the Medicaid **[**and**]** Pharmaceutical and Therapeutics Committee, shall adopt **[**a**]** preferred drug **[**list**]** lists for use in the Medicaid, state-administered general assistance and ConnPACE programs. The Department of Social Services, upon entering into a contract for the provision of prescription drug coverage to medical assistance recipients receiving services in a managed care setting as provided by section 7 of this act, shall in consultation with

the Medicaid Pharmaceutical and Therapeutics Committee, expand the preferred drug list for use in the HUSKY Plan, part A and Part B. To the extent feasible, the department shall review all drugs included **[**in**]** on the preferred drug **[**list**]** lists at least every twelve months, and may recommend additions to, and deletions from, the preferred drug **[**list**]** lists, to ensure that the preferred drug **[**list**]** lists provide for medically appropriate drug therapies for Medicaid, state-administered general assistance and ConnPACE patients. For the fiscal year ending June 30, 2004, such drug **[**list**]** lists shall be limited to use in the Medicaid and ConnPACE programs and cover three classes of drugs, including proton pump inhibitors and two other classes of drugs determined by the Commissioner of Social Services. **[**The commissioner shall notify the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations of the classes of drugs on the list by January 1, 2004.**]** Not later than June 30, 2005, the Department of Social Services, in consultation with the Medicaid Pharmaceutical and Therapeutic Committee shall expand such drug lists to include other classes of drugs, except as provided in subsection (f) of this section, in order to achieve savings reflected in the amounts appropriated to the department, for the various components of the program, in the state budget act.

(f) Except for mental-health-related drugs and antiretroviral drugs, reimbursement for a drug not included **[**in**]** on the preferred drug **[**list is**]** lists are subject to prior authorization.

(g) The Department of Social Services shall publish and disseminate the preferred drug **[**list**]** lists to all Medicaid providers in the state.

(h) The committee shall ensure that the pharmaceutical manufacturers agreeing to provide a supplemental rebate pursuant to 42 USC 1396r-8(c) have an opportunity to present evidence supporting inclusion of a product on the preferred drug **[**list**]** lists unless a court of competent jurisdiction, in a final decision, determines that the Secretary of Health and Human Services does not have authority to allow such supplemental rebates, provided the inability to utilize

supplemental rebates pursuant to this subsection shall not impair the committee's authority to maintain **[**a**]** preferred drug **[**list**]** lists. Upon timely notice, the department shall ensure that any drug that has been approved, or had any of its particular uses approved, by the United States Food and Drug Administration under a priority review classification, will be reviewed by the Medicaid Pharmaceutical and Therapeutics Committee at the next regularly scheduled meeting. To the extent feasible, upon notice by a pharmaceutical manufacturer, the department shall also schedule a product review for any new product at the next regularly scheduled meeting of the Medicaid Pharmaceutical and Therapeutics Committee.

(i) Factors considered by the department and the Medicaid Pharmaceutical and Therapeutics Committee in developing the preferred drug **[**list**]** lists shall include, but not be limited to, clinical efficacy, safety and cost effectiveness of a product.

(j) The Medicaid Pharmaceutical and Therapeutics Committee may also make recommendations to the department regarding the prior authorization of any prescribed drug covered by Medicaid in accordance with the plan developed and implemented pursuant to section 17b-491a.

(k) Medicaid recipients may appeal any department preferred drug list determinations utilizing the Medicaid fair hearing process administered by the Department of Social Services established pursuant to chapter 54.

[(l) The provisions of this section shall apply to the state-administered general assistance program.**]**

(l) The Commissioner of Social Services may contract with a pharmacy benefits organization or a single entity qualified to negotiate with pharmaceutical manufacturers for supplemental rebates, available pursuant to 42 USC 1396r-8(c), for the purchase of drugs listed on the preferred drug lists established pursuant to subsection (e) of this section.

Sec. 9. Section 17b-257 of the general statutes, as amended by section 18 of public act 03-2 and section 43 of public act 03-3 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) The Commissioner of Social Services shall implement a state medical assistance component of the state-administered general assistance program for persons ineligible for Medicaid. Not later than October 1, 2003, each person eligible for state-administered general assistance shall be entitled to receive medical care through a federally qualified health center or other primary care provider as determined by the commissioner. The Commissioner of Social Services shall determine appropriate service areas and shall, in the commissioner's discretion, contract with community health centers, other similar clinics, and other primary care providers, if necessary, to assure access to primary care services for recipients who live farther than a reasonable distance from a federally qualified health center. The commissioner shall assign and enroll eligible persons in federally qualified health centers and with any other providers contracted for the program because of access needs. Not later than October 1, 2003, each person eligible for state-administered general assistance shall be entitled to receive hospital services. Medical services under the program shall be limited to the services provided by a federally qualified health center, hospital, or other provider contracted for the program at the commissioner's discretion because of access needs. The commissioner shall ensure that ancillary services and specialty services are provided by a federally qualified health center, hospital, or other providers contracted for the program at the commissioner's discretion. Ancillary services include, but are not limited to, radiology, laboratory, and other diagnostic services not available from a recipient's assigned primary-care provider, and durable medical equipment. Specialty services are services provided by a physician with a specialty that are not included in ancillary services. In no event, shall ancillary or specialty services provided under the program exceed such services provided under the state-administered general assistance program on

July 1, 2003. Eligibility criteria concerning income shall be the same as the medically needy component of the Medicaid program, except that earned monthly gross income of up to one hundred fifty dollars shall be disregarded. Unearned income shall not be disregarded. No person who has family assets exceeding one thousand dollars shall be eligible. No person eligible for Medicaid shall be eligible to receive medical care through the state-administered general assistance program. No person shall be eligible for assistance under this section if such person made, during the three months prior to the month of application, an assignment or transfer or other disposition of property for less than fair market value. The number of months of ineligibility due to such disposition shall be determined by dividing the fair market value of such property, less any consideration received in exchange for its disposition, by five hundred dollars. Such period of ineligibility shall commence in the month in which the person is otherwise eligible for benefits. Any assignment, transfer or other disposition of property, on the part of the transferor, shall be presumed to have been made for the purpose of establishing eligibility for benefits or services unless such person provides convincing evidence to establish that the transaction was exclusively for some other purpose.

(b) Recipients covered by a general assistance program operated by a town shall be assigned and enrolled in federally qualified health centers and with any other providers in the same manner as recipients of medical assistance under the state-administered general assistance program pursuant to subsection (a) of this section.

(c) On and after October 1, 2003, pharmacy services shall be provided to recipients of state-administered general assistance through the federally qualified health center to which they are assigned or through a pharmacy with which the health center contracts. Prior to said date, pharmacy services shall be provided as provided under the Medicaid program. Recipients who are assigned to a community health center or similar clinic or primary care provider other than a federally qualified health center or to a federally qualified health center that does not have a contract for pharmacy services shall receive

pharmacy services at pharmacies designated by the commissioner.

[(d) Recipients of state-administered general assistance shall contribute a copayment of one dollar and fifty cents for each prescription.**]**

[(e)**]** (d) The Commissioner of Social Services shall contract with federally qualified health centers or other primary care providers as necessary to provide medical services to eligible state-administered general assistance recipients pursuant to this section. The commissioner shall, within available appropriations, make payments to such centers based on their pro rata share of the cost of services provided or the number of clients served, or both. The Commissioner of Social Services shall, within available appropriations, make payments to other providers based on a methodology determined by the commissioner. The Commissioner of Social Services may reimburse for extraordinary medical services, provided such services are documented to the satisfaction of the commissioner. For purposes of this section, the commissioner may contract with a managed care organization or other entity to perform administrative functions. Provisions of a contract for medical services entered into by the commissioner pursuant to this section shall supersede any inconsistent provision in the regulations of Connecticut state agencies.

[(f)**]** (e) Each federally qualified health center participating in the program shall, within thirty days of August 20, 2003, enroll in the federal Office of Pharmacy Affairs Section 340B drug discount program established pursuant to 42 USC 256b to provide pharmacy services to recipients at Federal Supply Schedule costs. Each such health center may establish an on-site pharmacy or contract with a commercial pharmacy to provide such pharmacy services.

[(g)**]** (f) The Commissioner of Social Services shall, within available appropriations, make payments to hospitals for inpatient services based on their pro rata share of the cost of services provided or the number of clients served, or both. The Commissioner of Social Services

shall, within available appropriations, make payments for any ancillary or specialty services provided to state-administered general assistance recipients under this section based on a methodology determined by the commissioner.

[(h)**]** (g) On or before March 1, 2004, the Commissioner of Social Services shall seek a waiver of federal law under the Health Insurance Flexibility and Accountability demonstration initiative for the purpose of extending health insurance coverage under Medicaid to persons qualifying for medical assistance under the state-administered general assistance program. The provisions of section 17b-8 shall apply to this section.

(h) The commissioner, pursuant to section 17b-10, as amended, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policy shall be valid until the time final regulations are adopted.

Sec. 10. Subsection (a) of section 17b-280 of the general statutes, as amended by section 11 of public act 03-2 and section 52 of public act 03-3 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) The state shall reimburse for all legend drugs provided under the Medicaid, state-administered general assistance, general assistance, ConnPACE and Connecticut AIDS drug assistance programs at the rate established by the Health Care Finance Administration as the federal acquisition cost, or, if no such rate is established, the commissioner shall establish and periodically revise the estimated acquisition cost in accordance with federal regulations. **[**Effective October 1, 2003, the**]** The commissioner shall also establish a professional fee of three dollars and **[**thirty**]** fifteen cents for each prescription to be paid to licensed pharmacies for dispensing drugs to

Medicaid, state-administered general assistance, general assistance, ConnPACE and Connecticut AIDS drug assistance recipients in accordance with federal regulations; and on and after September 4, 1991, payment for legend and nonlegend drugs provided to Medicaid recipients shall be based upon the actual package size dispensed. Effective October 1, 1991, reimbursement for over-the-counter drugs for such recipients shall be limited to those over-the-counter drugs and products published in the Connecticut Formulary, or the cross reference list, issued by the commissioner. The cost of all over-the-counter drugs and products provided to residents of nursing facilities, chronic disease hospitals, and intermediate care facilities for the mentally retarded shall be included in the facilities' per diem rate.

Sec. 11. Section 17b-95 of the general statutes, as amended by section 59 of public act 03-3 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Subject to the provisions of subsection (b) of this section, upon the death of a parent of a child who has, at any time, been a beneficiary under the program of aid to families with dependent children, the temporary family assistance program or the state-administered general assistance program, or upon the death of any person who has at any time been a beneficiary of aid under the state supplement program, medical assistance program, aid to families with dependent children program, temporary family assistance program or state-administered general assistance program, **[**and, on or after September 1, 2003, the Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program,**]** except as provided in subsection (b) of section 17b-93, the state shall have a claim against such parent's or person's estate for all amounts paid on behalf of each such child or for the support of either parent or such child or such person under the state supplement program, medical assistance program, aid to families with dependent children program, temporary family assistance program or state-administered general assistance program **[**and on or after September 1, 2003, to a beneficiary of aid under the Connecticut Pharmaceutical

Assistance Contract to the Elderly and Disabled Program,**]** for which the state has not been reimbursed, to the extent that the amount which the surviving spouse, parent or dependent children of the decedent would otherwise take from such estate is not needed for their support.

(b) In the case of any person dying after October 1, 1959, the claim for medical payments, even though such payments were made prior thereto, shall be restricted to medical disbursements actually made for care of such deceased beneficiary. **[**In the case of any person dying after September 1, 2003, the claim for ConnPACE program benefits shall be restricted to benefits actually received on or after July 1, 2003.**]**

(c) Claims pursuant to this section shall have priority over all unsecured claims against such estate, except (1) expenses of last sickness not to exceed three hundred seventy-five dollars, (2) funeral and burial expenses in accordance with section 17b-84, and (3) administrative expenses, including probate fees and taxes, and including fiduciary fees not exceeding the following commissions on the value of the whole estates accounted for by such fiduciaries: On the first two thousand dollars or portion thereof, five per cent; on the next eight thousand dollars or portion thereof, four per cent; on the excess over ten thousand dollars, three per cent. Upon petition by any fiduciary, the Probate Court, after a hearing thereon, may authorize compensation in excess of the above schedule for extraordinary services. Notice of any such petition and hearing shall be given to the Commissioner of Administrative Services in Hartford at least ten days in advance of such hearing. The allowable funeral and burial payment herein shall be reduced by the amount of any prepaid funeral arrangement. Any amount paid from the estate under this section to any person which exceeds the limits provided herein shall be repaid to the estate by such person, and such amount may be recovered in a civil action with interest at six per cent from the date of demand.

(d) For purposes of this section, all sums due on or after July 1, 2003, to any individual after the death of a public assistance beneficiary pursuant to the terms of an annuity contract purchased at any time

with assets of a public assistance beneficiary, shall be deemed to be part of the estate of the deceased beneficiary and shall be payable to the state by the recipient of such annuity payments to the extent necessary to achieve full reimbursement of any public assistance benefits paid to, or on behalf of, the deceased beneficiary irrespective of any provision of law. The recipient of beneficiary payments from any such annuity contract shall be solely liable to the state of Connecticut for reimbursement of public assistance benefits paid to, or on behalf of, the deceased beneficiary to the extent of any payments received by such recipient pursuant to the annuity contract.

Sec. 12. Subsection (a) of section 17b-492 of the general statutes, as amended by section 15 of public act 03-2, section 58 of public act 03-3 of the June 30 special session and public act 04-6, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Eligibility for participation in the program shall be limited to any resident (1) who is sixty-five years of age or older or who is disabled, (2) whose annual income, if unmarried, is less than twenty thousand eight hundred dollars, or whose annual income, if married, when combined with that of the resident's spouse is less than twenty-eight thousand one hundred dollars, (3) who is not insured under a policy which provides full or partial coverage for prescription drugs, except for a Medicare prescription drug discount card endorsed by the Secretary of Health and Human Services in accordance with Public Law 108-173, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, once a deductible amount is met, **[**(4) whose available assets are below one hundred thousand dollars if unmarried and one hundred twenty-five thousand dollars if married, (A) the asset limit for a married resident shall be determined by combining the value of assets available to both spouses, and (B) for purposes of this section, available assets are those that are considered available in determining eligibility in the Connecticut Home Care Program for the Elderly,**]** and **[**(5)**]** (4) on and after September 15, 1991, who pays an annual thirty-dollar registration fee to the Department of Social Services. Effective January 1, 2002, the commissioner shall

commence accepting applications from individuals who will become eligible to participate in the program as of April 1, 2002. On January 1, 1998, and annually thereafter, the commissioner shall increase the income limits established under this subsection over those of the previous fiscal year to reflect the annual inflation adjustment in Social Security income, if any. Each such adjustment shall be determined to the nearest one hundred dollars.

Sec. 13. Subsection (b) of section 17b-688c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(b) In no event shall temporary family assistance be granted to an applicant for such assistance, who is not exempt from participation in the employment services program, prior to the applicant's attendance at an initial scheduled employment services assessment interview and participation in the development of an employment services plan. The Department of Social Services shall not deny temporary family assistance to an applicant in cases where the department schedules the initial employment services assessment interview more than ten business days after the date on which application for assistance is made, or in cases where the Labor Department does not complete an employment services plan for the benefit of the applicant within ten business days of the date on which the applicant attends an employment services assessment interview. The Commissioner of Social Services shall refer any applicant denied temporary family assistance, who may be in need of emergency benefits, to other services offered by the Department of Social Services or community services that may be available to such applicant. The Department of Social Services shall reduce the benefits awarded to a family under the temporary family assistance program when a member of the family who is required to participate in employment services fails to comply with an employment services requirement without good cause. The first instance of noncompliance with an employment services requirement shall result in a twenty-five per cent reduction of such benefits for three consecutive months. The second instance of

noncompliance with such requirement shall result in a thirty-five per cent reduction of such benefits for three consecutive months. A third or subsequent instance of noncompliance with such requirement shall result in the termination of such benefits for three consecutive months. If only one member of a family is eligible for temporary family assistance and such member fails to comply with an employment services requirement, the department shall terminate all benefits of such family for three consecutive months. Notwithstanding the provisions of this subsection, the department shall terminate the benefits awarded to a family under the temporary family assistance program if a member of the family who is not exempt from the twenty-one-month time limit specified in subsection (a) of section 17b-112, as amended, fails, without good cause, to: (1) Attend any scheduled assessment appointment or interview relating to the establishment of an employment services plan, except that such individual's benefits shall be reinstated if the individual attends a subsequently scheduled appointment or interview within thirty days of the date on which the department has issued notification to the individual that benefits have been terminated, or (2) comply with an employment services requirement during a six-month extension of benefits. Any individual who fails to comply with the provisions of subdivision (1) of this subsection may submit a new application for such benefits at any time after termination of benefits.

Sec. 14. (NEW) (*Effective July 1, 2004*) At least two weeks before any entity in the state that administers vouchers under the federal Housing Choice Voucher Program, 42 USC 1437f(o), opens its waiting list for the acceptance of new applications for such vouchers, such entity shall notify, in writing or by electronic mail, the operator of an Internet web site designated by the Department of Social Services, of (1) the date of the opening of such waiting list, (2) the manner in which applicants may apply, and (3) the date, if any, on which the waiting list will be closed. The operator of said web site shall make such information available, by electronic means or otherwise, to Infoline of Connecticut, other organizations and the public.

Sec. 15. Subsection (a) of section 17b-112c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) Qualified aliens, as defined in Section 431 of Public Law 104-193, who do not qualify for federally-funded cash assistance, other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for solely state-funded temporary family assistance or cash assistance under the state-administered general assistance program, provided other conditions of eligibility are met. An individual who is granted assistance under this section must pursue citizenship to the maximum extent allowed by law as a condition of eligibility unless incapable of doing so due to a medical problem, language barrier or other reason as determined by the Commissioner of Social Services. Notwithstanding the provisions of this section, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has mental retardation shall be eligible for assistance under this section. **[**The commissioner shall not accept new applications for assistance under this subsection after June 30, 2003.**]**

Sec. 16. Section 17b-257b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

Qualified aliens, as defined in Section 431 of Public Law 104-193, admitted into the United States on or after August 22, 1996, other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law who have been determined eligible for Medicaid or for state-administered general assistance medical aid prior to July 1, 1997, may be eligible for state-funded medical assistance which shall provide coverage to the same extent as the Medicaid program, state-administered general assistance medical aid or the HUSKY Plan, Part B provided other conditions of eligibility are met. Such qualified aliens or lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing

under color of law who have not been determined eligible for Medicaid or for state-administered general assistance medical aid prior to July 1, 1997, shall be eligible for state-funded assistance or the HUSKY Plan, Part B subsequent to six months from establishing residency in this state. **[**The Commissioner of Social Services shall not accept applications for assistance pursuant to this section on or after June 30, 2003.**]** Notwithstanding the provisions of this section, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has mental retardation shall be eligible for state-funded assistance or the HUSKY Plan, Part B pursuant to this section. Only individuals who are not eligible for Medicaid shall be eligible for state-funded assistance pursuant to this section.

Sec. 17. Subsection (a) of section 17b-342 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) The Commissioner of Social Services shall administer the Connecticut home-care program for the elderly state-wide in order to prevent the institutionalization of elderly persons (1) who are recipients of medical assistance, (2) who are eligible for such assistance, (3) who would be eligible for medical assistance if residing in a nursing facility, or (4) who meet the criteria for the state-funded portion of the program under subsection (i) of this section. For purposes of this section, a long-term care facility is a facility which has been federally certified as a skilled nursing facility or intermediate care facility. The commissioner shall make any revisions in the state Medicaid plan required by Title XIX of the Social Security Act prior to implementing the program. The annualized cost of the community-based services provided to such persons under the program shall not exceed sixty per cent of the weighted average cost of care in skilled nursing facilities and intermediate care facilities. The program shall be structured so that the net cost to the state for long-term facility care in combination with the community-based services under the program

shall not exceed the net cost the state would have incurred without the program. The commissioner shall investigate the possibility of receiving federal funds for the program and shall apply for any necessary federal waivers. A recipient of services under the program, and the estate and legally liable relatives of the recipient, shall be responsible for reimbursement to the state for such services to the same extent required of a recipient of assistance under the state supplement program, medical assistance program, temporary family assistance program or food stamps program. Only a United States citizen or a noncitizen who meets the citizenship requirements for eligibility under the Medicaid program shall be eligible for home-care services under this section, except a qualified alien, as defined in Section 431 of Public Law 104-193, admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for services under this section prior to July 1, 1997, shall remain eligible for such services. **[**The Commissioner of Social Services shall not accept applications for assistance pursuant to this section from a qualified alien, as defined in Section 431 of Public Law 104-193, or other lawfully residing immigrant alien after June 30, 2003.**]** Qualified aliens or other lawfully residing immigrant aliens not determined eligible prior to July 1, 1997, shall be eligible for services under this section subsequent to six months from establishing residency. Notwithstanding the provisions of this subsection, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has mental retardation shall be eligible for assistance pursuant to this section. Qualified aliens, as defined in Section 431 of Public Law 104-193, or other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for services under this section provided other conditions of eligibility are met.

Sec. 18. Subsection (a) of section 17b-790a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) The Commissioner of Social Services, within available appropriations, shall establish a food assistance program for individuals entering the United States prior to April 1, 1998, whose immigrant status meets the eligibility requirements of the federal Food Stamp Act of 1977, as amended, but who are no longer eligible for food stamps solely due to their immigrant status under Public Law 104-193. **[**The commissioner shall not accept new applications for assistance under this section after June 30, 2003.**]** Individuals who enter the United States after April 1, 1998, must have resided in the state for six months prior to becoming eligible for the state program. The commissioner may administer such program in accordance with the provisions of the federal food stamp program, except those pertaining to the determination of immigrant status under Public Law 104-193.

Sec. 19. Section 17a-151aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) Any state agency that places a child, as defined in section 17a-93, in a residential facility shall enter into a written agreement with the facility at the time of the placement. Such written agreement shall establish clear standards for the child's care and treatment, including, but not limited to, requirements for monthly written reports concerning the child's care and treatment, addressed to the case worker overseeing the child's placement. The monthly written reports shall set forth child-specific goals and expectations for treatment and progress. The written agreement shall require the facility to report promptly to the placing agency any allegation that the child is abused or neglected, as defined in section 46b-120, or any incident of abuse or neglect of an individual placed in the facility. The placing agency shall ensure that a discharge plan is initiated **[**within**]** no later than two weeks **[**of**]** after the child's placement in the facility.

(b) In the case of a child placed by the Department of Children and Families in a residential facility in another state, the Commissioner of Children and Families shall ensure that a representative of the department makes in-person visits with the child no less frequently

than every two months in order to assess the well being of the child.

Sec. 20. (*Effective July 1, 2004*) The Children's Trust Fund Council and the Department of Children and Families shall enter into an agreement whereby the department will transfer to the council eight hundred eighty-three thousand dollars that was appropriated to the department in house bill 5692 of the current session. Such amount shall be used by the council for expansion of the Nurturing Families Program in Hartford and for staff and expenses associated with such expansion.

Sec. 21. (*Effective July 1, 2004*) $1,000,000 appropriated to the Department of Education, Magnet Schools in section 11 of public act 03-1 of the June 30 special session, as amended by section 1 of house bill 5692 of the current session, shall be transferred to the Department of Mental Retardation, Community Residential Services account, to provide residential services to individuals on the department's waiting list.

Sec. 22. Section 19a-644 of the general statutes, as amended by section 76 of public act 03-278, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) On or before February twenty-eighth annually, for the fiscal year ending on September thirtieth of the immediately preceding year, each short-term acute care general or children's hospital shall report to the office with respect to its operations in such fiscal year, in such form as the office may by regulation require. Such report shall include: (1) Average salaries in each department of administrative personnel, supervisory personnel and direct service personnel by job classification; (2) salaries and fringe benefits for the ten highest paid positions; (3) the name of each joint venture, partnership, subsidiary and corporation related to the hospital; and (4) the salaries paid to hospital employees by each such joint venture, partnership, subsidiary and related corporation and by the hospital to the employees of related corporations. In addition, such report may, at the discretion of the

office, include a breakdown of hospital and department budgets by administrative, supervisory and direct service categories, by total dollars, by full-time equivalent staff or any combination thereof, which the office may request at any time of the year, provided the office gives the hospital at least thirty days from the date of the request to provide the information.

(b) The office shall adopt regulations in accordance with chapter 54 to provide for the collection of data and information in addition to the annual report required in subsection (a) of this section. Such regulations shall provide for the submission of information about the operations of the following entities: Persons or parent corporations that own or control the health care facility, institution or provider; corporations, including limited liability corporations, in which the health care facility, institution, provider, its parent, any type of affiliate or any combination thereof, owns more than an aggregate of fifty per cent of the stock or, in the case of nonstock corporations, is the sole member; and any partnerships in which the person, health care facility, institution, provider, its parent or an affiliate or any combination thereof, or any combination of health care providers or related persons, owns a greater than fifty per cent interest. For purposes of this section, "affiliate" means any person that directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with any health care facility, institution, provider or person that is regulated in any way under this chapter. A person is deemed controlled by another person if the other person, or one of that other person's affiliates, officers, agents or management employees, acts as a general partner or manager of the person in question.

(c) Each nonprofit short-term acute care general or children's hospital shall include in the annual report required pursuant to subsection (a) of this section a report of all transfers of assets, transfers of operations or changes of control involving its clinical or nonclinical services or functions from such hospital to a person or entity organized or operated for profit.

[(c)**]** (d) The Office of Health Care Access shall require each hospital licensed by the Department of Public Health, that is not subject to the provisions of subsection (a) of this section, to report to said office on its operations in the preceding fiscal year by filing copies of the hospital's audited financial statements. Such report shall be due at said office on or before the close of business on the last business day of the fifth month following the month in which a hospital's fiscal year ends.

Sec. 23. Section 19a-486c of the general statutes, as amended by section 4 of public act 03-73, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) The Attorney General shall deny an application as not in the public interest if the Attorney General determines that one or more of the following conditions exist: (1) The transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities; (2) the nonprofit hospital failed to exercise due diligence in (A) deciding to transfer, (B) selecting the purchaser, (C) obtaining a fairness evaluation from an independent person expert in such agreements, or (D) negotiating the terms and conditions of the transfer; (3) the nonprofit hospital failed to disclose any conflict of interest, including, but not limited to, conflicts of interest pertaining to board members, officers, key employees and experts of the hospital, the purchaser or any other party to the transaction; (4) the nonprofit hospital will not receive fair market value for its assets, which, for purposes of this subsection, means the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market; (5) the fair market value of the assets has been manipulated by any person in a manner that causes the value of the assets to decrease; (6) the financing of the transaction by the nonprofit hospital will place the nonprofit hospital's assets at an unreasonable risk; (7) any management contract contemplated under the transaction is not for reasonable fair value; (8) a sum equal to the fair market value of the

nonprofit hospital's assets (A) is not being transferred to one or more persons to be selected by the superior court for the judicial district where the nonprofit hospital is located who are not affiliated through corporate structure, governance or membership with either the nonprofit hospital or the purchaser, unless the nonprofit hospital continues to operate on a nonprofit basis after the transaction and such sum is transferred to the nonprofit hospital to provide health care services, and (B) is not being used for one of the following purposes: (i) For appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose, (ii) for the support and promotion of health care generally in the affected community, or (iii) with respect to any assets held by the nonprofit hospital that are subject to a use restriction imposed by a donor, for a purpose consistent with the intent of said donor; or (9) the nonprofit hospital or the purchaser has failed to provide the Attorney General with information and data sufficient to evaluate the proposed agreement adequately, provided the Attorney General has notified the nonprofit hospital or the purchaser of the inadequacy of the information or data and has provided a reasonable opportunity to remedy such inadequacy.

(b) The Attorney General may, during the course of a review required by section 19a-486b, as amended: (1) Issue in writing and cause to be served upon any person, by subpoena, a demand that such person appear before the Attorney General and give testimony or produce documents as to any matters relevant to the scope of the review; or (2) issue written interrogatories, to be answered under oath, as to any matters relevant to the scope of the review and prescribing a return date that would allow a reasonable time to respond. If any person fails to comply with the provisions of this subsection, the Attorney General may apply to the superior court for the judicial district of Hartford seeking enforcement of the subpoena. The superior court may, upon notice to such person, issue and cause to be served an order requiring compliance. Service of subpoenas ad testificandum, subpoenas duces tecum, notices of deposition and written

interrogatories as provided in this subsection may be made by personal service at the usual place of abode or by certified mail, return receipt requested, addressed to the person to be served at such person's principal place of business within or without this state or such person's residence.

(c) The Attorney General may contract with experts or consultants to assist in reviewing the proposed agreement, including, but not limited to, assistance in independently determining the fair market value of the nonprofit hospital's assets. The Attorney General may appoint, or contract with, another person to conduct the review required by this section and make recommendations to the Attorney General. The Attorney General shall submit any bills for such contracts to the purchaser. The purchaser shall pay such bills within thirty days of receipt. Such bills shall not exceed three hundred thousand dollars.

Sec. 24. Subsection (a) of section 19a-486d of the general statutes, as amended by section 5 of public act 03-73, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) The commissioner shall deny an application filed pursuant to subsection (d) of section 19a-486a, as amended by this act, unless the commissioner finds that: (1) The affected community will be assured of continued access to affordable health care; (2) in a situation where the asset or operation to be transferred provides or has provided health care services to the uninsured or underinsured, the purchaser has made a commitment to provide health care to the uninsured and the underinsured; (3) in a situation where health care providers or insurers will be offered the opportunity to invest or own an interest in the purchaser or an entity related to the purchaser safeguard procedures are in place to avoid a conflict of interest in patient referral; and (4) certificate of need authorization is justified in accordance with sections 19a-637 to 19a-639, inclusive, as amended. The commissioner may contract with any person, including, but not limited to, financial or actuarial experts or consultants, or legal experts with the approval of the Attorney General, to assist in reviewing the completed application.

The commissioner shall submit any bills for such contracts to the purchaser. Such bills shall not exceed one hundred fifty thousand dollars. The purchaser shall pay such bills no later than thirty days after the date of receipt of such bills.

Sec. 25. Subsection (b) of section 17a-50 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(b) There shall be established, within existing resources, a Children's Trust Fund Council which shall be within the Department of Children and Families for administrative purposes only. The council shall be composed of sixteen members as follows: (1) The Commissioners of the Departments of Social Services, Education, Children and Families and Public Health, or their designees; (2) a representative of the business community with experience in fund-raising, appointed by the president pro tempore of the Senate; (3) a representative of the business community with experience in fund-raising, appointed by the speaker of the House of Representatives; (4) a representative of the business community with experience in fund-raising, appointed by the minority leader of the House of Representatives; (5) a representative of the business community with experience in fund-raising, appointed by the minority leader of the Senate; (6) a parent, appointed by the majority leader of the House of Representatives; (7) a parent, appointed by the majority leader of the Senate; (8) a parent, appointed by the president pro tempore of the Senate; (9) a person with expertise in child abuse prevention, appointed by the speaker of the House of Representatives; (10) a person with expertise in child abuse prevention, appointed by the minority leader of the House of Representatives; (11) a staff member of a child abuse prevention program, appointed by the minority leader of the Senate; (12) a staff member of a child abuse prevention program, appointed by the majority leader of the House of Representatives; and (13) a pediatrician, appointed by the majority leader of the Senate. The council shall solicit and accept funds, on behalf of the Children's Trust Fund, to be used for the prevention of child abuse and neglect and

family resource programs, or on behalf of the Parent Trust Fund, to be used for parent community involvement to improve the health, safety and education of children, and shall make grants to programs pursuant to subsections (a) and (c) of this section. The council may, subject to the provisions of chapter 67, employ an executive director and any necessary staff within available appropriations.

Sec. 26. (NEW) (*Effective July 1, 2004*) (a) Notwithstanding any provision of the general statutes or any special act, the Commissioner of Veterans' Affairs, on behalf of any facility operated by the commissioner and established by the state for the care of veterans**,** may apply to the Department of Public Health for: (1) A license for a chronic and convalescent nursing home, as defined in section 19a-521 of the general statutes; (2) a license for a rest home with nursing supervision, as defined in section 19a-521 of the general statutes; or (3) a license for an assisted living services agency, as defined in section 19a-490 of the general statutes, as amended.

(b) Notwithstanding any provision of the general statutes or any special act, in the event the commissioner applies for a license under subsection (a) of this section, the Veterans Home and Hospital may retain such home and hospital's chronic disease hospital license.

(c) The Department of Public Health shall process an application for any license submitted under subsection (a) of this section in an expedited manner.

(d) Notwithstanding the provisions of chapter 319y of the general statutes and the regulations of Connecticut state agencies, any Veterans' Home and Hospital project undertaken pursuant to a license application as provided in subsection (a) of this section shall not be subject to certificate of need application and approval requirements applicable to nursing home services, including beds, additions and capital expenditures.

(e) Notwithstanding any provision of the general statutes or any special act, the Veterans' Home and Hospital project undertaken

pursuant to a license application as provided in subsection (a) of this section shall be exempt from the requirements for approval of a request or application provided for in section 19a-638 of the general statutes, as amended.

Sec. 27. Subsection (d) of section 17b-112 of the general statutes, as amended by section 1 of public act 03-28 and section 5 of public act 03-268, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) Under said program (1) no family shall be eligible that has total gross earnings exceeding the federal poverty level, however, in the calculation of the benefit amount for eligible families and previously eligible families that become ineligible temporarily because of receipt of workers' compensation benefits by a family member who subsequently returns to work immediately after the period of receipt of such benefits, earned income shall be disregarded up to the federal poverty level; (2) the increase in benefits to a family in which an infant is born after the initial ten months of participation in the program shall be limited to an amount equal to fifty per cent of the average incremental difference between the amounts paid per each family size; and (3) a disqualification penalty shall be established for failure to cooperate with the biometric identifier system. Except when determining eligibility for a six-month extension of benefits pursuant to subsection (c) of this section, the commissioner shall disregard the first fifty dollars per month of income attributable to <u>current</u> child support that a family receives in determining eligibility and benefit levels for temporary family assistance. <u>Any current child support in excess of fifty dollars per month collected by the department on behalf of an eligible child shall be considered in determining eligibility but shall not be considered when calculating benefits and shall be taken as reimbursement for assistance paid under this section, except that when the current child support collected exceeds the family's monthly award of Temporary Family Assistance benefits plus fifty dollars, the current child support shall be paid to the family and shall be considered when calculating benefits.</u>

Sec. 28. Subsection (f) of section 17b-363a of the general statutes, as amended by section 1 of public act 03-116 and section 146 of public act 03-6 of the June 30 special session, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(f) Any long-term care facility that violates or fails to comply with the provisions of this section shall be fined not more than thirty thousand dollars for each incidence of noncompliance. The **[**commissioner**]** Commissioner of Social Services may offset payments due a facility to collect the penalty. Prior to imposing any penalty pursuant to this subsection, the commissioner shall notify the long-term care facility of the alleged violation and the accompanying penalty and shall permit such facility to request that the department review its findings. A facility shall request such review **[**within**]** not later than fifteen days **[**of**]** after receipt of the notice of violation from the department. The department shall stay the imposition of any penalty pending the outcome of the review. The commissioner may impose a penalty upon a facility pursuant to this subsection regardless of whether a change in ownership of the facility has taken place since the time of the violation, provided the department issued notice of the alleged violation and the accompanying penalty prior to the effective date of the change in ownership and record of such notice is readily available in a central registry maintained by the department. Payments of fines received pursuant to this subsection shall be deposited in the General Fund and credited to the Medicaid account.

Sec. 29. (*Effective July 1, 2004*) The sum of $75,000 is appropriated to the Department of Public Health from the General Fund, for the fiscal year ending June 30, 2005, for a school based health clinic in Norwich.

Sec. 30. (*Effective July 1, 2004*) The sum of $75,000 appropriated to the Department of Children and Families, Community Based Prevention programs, in section 1 of House Bill 5692 of the current session, is transferred to the Department of Social Services for Teen Pregnancy Prevention.

Sec. 31. (*Effective July 1, 2004*) The sum of $50,000 is appropriated to The University of Connecticut from the General Fund for the fiscal year ending June 30, 2005, for the Veterinary Diagnostic Laboratory.

Sec. 32. (*Effective July 1, 2004*) Up to $250,000 appropriated to the Department of Social Services for the fiscal year ending June 30, 2004, for Safety Net Services shall not lapse June 30, 2004, and shall be available for expenditure during the fiscal year ending June 30, 2005, for the Employment Success program.

Sec. 33. (*Effective July 1, 2004*) Up to $60,000 appropriated to the Department of Mental Health and Addiction Services, for the fiscal year ending June 30, 2004, for Housing Supports and Services, shall not lapse June 30, 2004, and shall be available for expenditure during the fiscal year ending June 30, 2005 for Housing Supports and Services.

Sec. 34. (NEW) (*Effective July 1, 2004*) The Department of Mental Health and Addiction Services, in collaboration with the Department of Children and Families, shall provide behavioral health services, on a transitional basis, for the dependents and any member of any reserve component of the armed forces of the United States who has been called to active service in the armed forces of this state or the United States for Operation Enduring Freedom or Operation Iraqi Freedom. Such transitional services shall be provided when no Department of Defense coverage for such services is available or such member is not eligible for such services through the Department of Defense, until an approved application is received from the federal Department of Veterans' Affairs and coverage is available to such member and such member's dependents.

Sec. 35. (*Effective July 1, 2004*) (a) Up to $51,900 of the unexpended balance of funds appropriated to the Office of the Chief Medical Examiner in section 1 of public act 03-1 of the June 30 special session, for Other Expenses, shall not lapse June 30, 2004, and such funds shall continue to be available for expenditure, for Case Management, during the fiscal year ending June 30, 2005.

(b) The unexpended balance of funds appropriated to the Office of the Chief Medical Examiner, for the fiscal year ending June 30, 2000, for Equipment, and carried forward in accordance with subsection (b) of section 35 of public act 03-1 of the June 30 special session, shall not lapse June 30, 2004, and such funds shall continue to be available for expenditure for such purpose during the fiscal year ending June 30, 2005.

Sec. 36. (NEW) (*Effective July 1, 2004*) Notwithstanding the provisions of section 502 of house amendment schedule "B" of house bill 5692 of the current session, the funds required by said section 502 to be allocated to the Department of Mental Health and Addiction Services for Grants for Mental Health Services shall be deposited in a separate, nonlapsing account established within the General Fund. Said account shall be the Mental Health Services Grants account, and shall contain any other moneys required by law to be deposited in said account. The moneys in said account shall be expended as provided by law.

Sec. 37 Section 17b-749 of the general statutes, as amended by section 16 of public act 03-2, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) The Commissioner of Social Services shall establish and operate a child care subsidy program to increase the availability, affordability and quality of child care services for families with a parent or caretaker who is working, attending high school or who receives cash assistance under the temporary family assistance program from the Department of Social Services and is participating in an approved education, training, or other job preparation activity. Services available under the child care program shall include the provision of child care subsidies for children under the age of thirteen or children under the age of nineteen with special needs. <u>The department shall open and maintain enrollment for the child care subsidy program and shall administer such program within the existing budgetary resources available.</u>

(b) The commissioner shall establish income standards for applicants and recipients at a level to include a family with gross income up to fifty per cent of the state-wide median income, except the commissioner (1) may increase the income level to up to seventy-five per cent of the state-wide median income, (2) upon the request of the Commissioner of Children and Families, may waive the income standards for adoptive families so that children adopted on or after October 1, 1999, from the Department of Children and Families are eligible for the child care subsidy program, and (3) on and after March 1, 2003, the commissioner shall reduce the income eligibility level to up to fifty-five per cent of the state-wide median income for applicants and recipients who qualify based on their loss of eligibility for temporary family assistance. The commissioner may adopt regulations in accordance with chapter 54 to establish income criteria and durational requirements for such waiver of income standards.

(c) The commissioner shall establish eligibility and program standards including, but not limited to: (1) A priority intake and eligibility system with preference given to serving recipients of temporary family assistance who are employed or engaged in employment activities under the department's "Jobs First" program, working families whose temporary family assistance was discontinued not more than five years prior to the date of application for the child care subsidy program, teen parents, low-income working families, adoptive families of children who were adopted from the Department of Children and Families and who are granted a waiver of income standards under subdivision (2) of subsection (b), and working families who are at risk of welfare dependency; (2) health and safety standards for child care providers not required to be licensed; (3) a reimbursement system for child care services which account for differences in the age of the child, number of children in the family, the geographic region and type of care provided by licensed and unlicensed caregivers, the cost and type of services provided by licensed and unlicensed caregivers, successful completion of fifteen hours of annual in-service training or credentialing of child care

directors and administrators, and program accreditation; (4) supplemental payment for special needs of the child and extended nontraditional hours; (5) an annual rate review process which assures that reimbursement rates are maintained at levels which permit equal access to a variety of child care settings; (6) a sliding reimbursement scale for participating families; (7) an administrative appeals process; (8) an administrative hearing process to adjudicate cases of alleged fraud and abuse and to impose sanctions and recover overpayments; and (9) a waiting list for the child care subsidy program that reflects the priority and eligibility system set forth in subdivision (1) of this subsection, which is reviewed periodically, with the inclusion of this information in the annual report required to be issued annually by the Department of Social Services to the Governor and the General Assembly in accordance with subdivision (10) of section 17b-733. Such action will include, but not be limited to, family income, age of child, region of state and length of time on such waiting list.

(d) On or after January 1, 1998, a provider under the child care subsidy program that qualifies for eligibility and subsequently receives payment for child care services for recipients under this section shall be reimbursed for such services until informed by the Department of Social Services of the parent's ineligibility.

(e) All licensed child care providers and those providers exempt from licensing shall provide the Department of Social Services with the following information in order to maintain eligibility for reimbursement: (1) The name, address, appropriate identification, Social Security number and telephone number of the provider and all adults who work for or reside at the location where care is provided; (2) the name and address of the child's doctor, primary care provider and health insurance company; (3) whether the child is immunized and has had health screens pursuant to the federal Early and Periodic Screening, Diagnostic and Treatment Services Program under 42 USC 1396d; and (4) the number of children cared for by the provider.

(f) On or after January 1, 1998, the commissioner shall adopt

regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section.

Sec. 38. Section 44 of public act 03-3 of the June 30 special session is repealed and the following is substituted in lieu thereof:

[(a) An applicant for state-administered general assistance cash or medical benefits aggrieved by a decision of the Commissioner of Social Services under the program operated pursuant to section 17b-190 and 17b-257 may request a hearing pursuant to section 17b-60, but shall not be eligible for state-administered general assistance cash or medical benefits pending a hearing decision.

(b) A recipient of state-administered general assistance cash assistance aggrieved by a decision of the Commissioner of Social Services under the program operated pursuant to section 17b-190 may request a hearing pursuant to section 17b-60, but shall not be eligible for the continuation of cash assistance pending a hearing decision.

(c) A recipient of state-administered general assistance medical program benefits aggrieved by a decision of the Commissioner of Social Services under the program operated pursuant to section 17b-257 may request a hearing pursuant to section 17b-60 and shall continue to receive medical benefits pending a hearing decision.**]**

A person whose application for State Administered General Assistance cash or medical benefits is denied or whose receipt of such assistance is terminated or modified may request a hearing pursuant to section 17b-60, provided a recipient of medical benefits who seeks review of a denial of coverage for a specific medical service shall exhaust the grievance process available pursuant to section 17b-257, as amended by this act, prior to requesting such a hearing.

Sec. 39. Section 19a-528a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

[Any**]** For any application of licensure for the acquisition of a

nursing home filed after July 1, 2004, any potential nursing home licensee or owner **[**who**]** must submit in writing, a change in ownership application with respect to facility for which the change in ownership is sought. Such application shall include whether such potential nursing home licensee or owner (1) has had **[**four**]** civil penalties imposed through final order of the commissioner in accordance with the provisions of sections 19a-524 to 19a-528, inclusive, or civil penalties imposed pursuant to the statutes or regulations of another state, during a two-year period, (2) has had in any state intermediate sanctions imposed through final adjudication under the Medicare or Medicaid program pursuant to Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as from time to time amended, or (3) has had in any state such potential licensee's or owner's Medicare or Medicaid provider agreement terminated or not renewed, shall not acquire another nursing home in this state for a period of five years from the date of final order on such civil penalties, final adjudication of such intermediate sanctions, or termination or nonrenewal. Notwithstanding, the provisions of this section, the Commissioner of Public Health, may for good cause shown, permit a potential nursing home licensee or owner to acquire another nursing home prior to the expiration of said five-year period.

Sec. 40. (NEW) (*Effective July 1, 2004*) (a) Until June 30, 2006, the Commissioner of Social Services shall, within available appropriations, establish and operate a state-funded pilot program to allow no more than one hundred persons who are sixty-five years of age or older and meet the eligibility requirements of the Connecticut home-care program for the elderly established under section 17b-342 of the general statutes to receive personal care assistance as an alternative covered service to home health services in order to avoid institutionalization, provided the average annual cost to the state per recipient of personal care assistance under the pilot program does not exceed the average annual cost to the state per recipient of home health services under the home-care program. Personal care assistance under the program may be provided by nonspousal family members of the

recipient of services under the program.

(b) In conducting the pilot program, the commissioner or the commissioner's agent (1) may require as a condition of participation that participants in the pilot program disclose if a personal care assistant is a nonspousal family member, (2) shall monitor the provision of services under the pilot program, and (3) shall ensure the cost-effectiveness of the pilot program.

(c) The commissioner shall establish the maximum allowable rate to be paid for such services under the pilot program and may set a separate lower rate for nonspousal family members providing services as personal care assistants in the pilot program if deemed necessary by the commissioner to ensure cost effectiveness of the pilot program and to conduct the pilot program within available appropriations.

(d) Not later than January 1, 2006, the Commissioner of Social Services shall submit a report on the pilot program to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services and to the select committee of the General Assembly having cognizance of matters relating to aging. The report shall include information on the quality of services provided under the pilot program and shall be submitted in accordance with section 11-4a of the general statutes.

Sec. 41. (NEW) (*Effective from passage*) The Commissioner of Social Services, pursuant to section 17b-342 of the general statutes, shall apply to the Centers for Medicaid and Medicare Services for a waiver to include in the Medicaid funded home-care program the pilot program established in section 501 of this act. In no event shall the number of pilot program participants exceed one hundred persons.

Sec. 42. (*Effective from passage*) Section 1 of public act 04-81 shall take effect from passage.

Sec. 43. (*Effective July 1, 2004*) Sections 69 and 72 of public act 03-3 of the June 30 special session and section 11 of public act 03-1 of the

September 8 special session are repealed."

This act shall take effect as follows:	
Section 1	*July 1, 2004*
Sec. 2	*July 1, 2004*
Sec. 3	*July 1, 2004*
Sec. 4	*from passage*
Sec. 5	*July 1, 2004*
Sec. 6	*July 1, 2004*
Sec. 7	*July 1, 2004*
Sec. 8	*July 1, 2004*
Sec. 9	*July 1, 2004*
Sec. 10	*July 1, 2004*
Sec. 11	*from passage*
Sec. 12	*from passage*
Sec. 13	*July 1, 2004*
Sec. 14	*July 1, 2004*
Sec. 15	*July 1, 2004*
Sec. 16	*July 1, 2004*
Sec. 17	*July 1, 2004*
Sec. 18	*July 1, 2004*
Sec. 19	*July 1, 2004*
Sec. 20	*July 1, 2004*
Sec. 21	*July 1, 2004*
Sec. 22	*July 1, 2004*
Sec. 23	*July 1, 2004*
Sec. 24	*July 1, 2004*
Sec. 25	*July 1, 2004*
Sec. 26	*July 1, 2004*
Sec. 27	*from passage*
Sec. 28	*July 1, 2004*
Sec. 29	*July 1, 2004*
Sec. 30	*July 1, 2004*
Sec. 31	*July 1, 2004*
Sec. 32	*July 1, 2004*
Sec. 33	*July 1, 2004*
Sec. 34	*July 1, 2004*
Sec. 35	*July 1, 2004*
Sec. 36	*July 1, 2004*

Sec. 37	*July 1, 2004*
Sec. 39	*July 1, 2004*
Sec. 40	*July 1, 2004*
Sec. 41	*from passage*
Sec. 42	*from passage*
Sec. 43	*July 1, 2004*